WEEKLY CLAIM FORM
SHORT-TIME (STC) COMPENSATION PLAN

VERMONT DEPARTMENT OF LABOR

UNIT NAME	EMPLOYER NAME	SATURDAY WEEK ENDING DATE
SOCIAL SECURITY NUMBER	PARTICIPANT NAME	/ /

INSTRUCTIONS FOR COMPLETING THE PARTICIPANT WEEKLY CLAIM FORM

This individual claim form must be completed by each participating employee each week throughout the duration of the approved STC Plan. It should be prepared within 2 calendar days after the end of the week being reported and given to the STC employer for mailing to the STC Unit along with the Employer's Weekly Report form.

Failure to complete all items on the Weekly Claim form may cause a **delay or denial** of unemployment benefits.

ANSWER ALL OF THE FOLLOWING QUESTIONS:

1. Enter the number of hours and minutes you worked during the reported week for the STC employer. HRS: _____ MINS: _____

   If you worked less than 20 hours for the STC employer, also indicate the gross wages* earned $ _____.

> * The term wages means all remuneration for services rendered by an individual, including commission, bonuses, gratuities, cash value of any non-cash items (such as board, rent, fuel, offset of a debt, and the like and income from self employment). Report GROSS WAGES before deductions, whether or not received, for employment beginning Sunday, ending Saturday, for the week ending date indicated above. Self employment expenses cannot be deducted.

2. Will you receive, or have your received, wages or income from any other source for work performed or from self employment during the reported week? ☐ Yes ☐ No

   If YES, list source name (or self), hours worked and **gross** wages *earned*:

Source Name:	Worked Hrs. / Mins.	Gross Wages*
_____	____ / ____	$ _____
_____	____ / ____	$ _____

3. During the reported week, if you did receive, or if you expect to receive any of the following kinds of remuneration, enter the amounts in dollars and cents, in the spaces provided. Be sure to enter the hours for Vacation Pay/Personal Pay, Sick or Holiday Pay when applicable.

Vacation Pay/Personal Pay	**Sick or "Wellness" Pay**	**Holiday Pay**	**Workers' Compensation**
List Hours/Mins: _____	List Hours/Mins: _____	List Hours/Mins: _____	
$ _____	$ _____	$ _____	$ _____

		Yes	**No**	
4. a.	Did you work all hours the employer had available?	☐	☐	If No, give reason _____
b.	Were you able to work and available for work?	☐	☐	If No, give reason _____
c.	Did you refuse any offer of work or referral to work?	☐	☐	If Yes, give reason _____
d.	Did you quit a job?	☐	☐	If Yes, give reason _____
e.	Were you fired from work?	☐	☐	If Yes, give reason _____
f.	Did you or will you receive a back pay award or settlement?	☐	☐	If Yes, give reason _____

5. If you have changed your name, address or telephone number since filing your last claim, please complete the following section:

_____ _____
Name Telephone Number

_____
Address - Street City State ZIP Code

CERTIFICATION: *I understand that the law prescribes PENALTIES for FALSE STATMENTS to obtain or increase benefits and that I will have to repay any benefits falsely obtained. I hereby certify that the information contained in this claim is true and correct.*

_____ _____
Claimant Signature Date
(***There must be an original signature <u>each week</u>. No photocopy.)*** ***(This form cannot be signed prior to the week ending date listed above.)***